Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTH TEXAS REHABILITATION CENTER
214 W. COLORADO
DALLAS TX 75208-4514

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

INDEMNITY INSURANCE CO OF NORT

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-11-1664-01

MFDR Received Date

January 24, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "provider requested work Hardening from Adjuster Terry Vangen we were given approval that it was ok to proceed because it falls within the ODG guidliens for tensynovitis. The adjuster used a peer review after the fact to deny our medical bills. Statin ghte injury had resolved, our treatment, helped return the pt to work.."

Amount in Dispute: $8,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provier's Request for Medical Fee Dispute Resolution involves reimbursement for a work hardening program. The Providered performed work hardening services and billed the Carrier. The Carrier reviewed the billing and denied reimbursement after determining the services did not constitute reasonable and necessary treatment. The Carrier reviewed the billing and denied reimbursement after determining the services did not constitute reasonable and necessary treatment… This Requestof or Medical Fee Dispute Resolution should be dismissed. The Carrier has no record of receiving a request for reconsideration on any of the dates of service in dispute, nor does the Provider submit any documentation support a request for reconsideration was filed. Consequently, the Request should be dismissed under Rule 133.307(e)(3)©. Furthermore, the Carrier reviewed the disputed billing and disputed the billing based on a lack of medical necessity. As such this is a medical necessity dispute and not a medical fee dispute. The Provider's remedy is afforded under Rule 133.308, not through Medical Fee Dispute Resolution. Consequently, this Request should also be dismissed under Rule 133.307(e)(3)(G."

Response Submitted by: Travelers, 1401 S. Mopac Expressway, ste. A-320, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 19, 2010 through February 19, 2010	CPT Code 97545-WH-CA CPT Code 97545-WH-CA	$8,000.00	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO)..
4. 28 Texas Administrative Code §133.250 sets out the procedures for reconsideration for medical bills.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 1, 2010, March 2, 2010, and March 5, 2010
   - W9 - Unnecessary medical treatment based on peer review.

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Codes §§§133.305, 133.307, and 133.308?
2. Did the requester support that the request for reconsideration was made in accordance with 28 Texas Administrative Code §133.250?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor states in their position summary that they were "given approval that it was ok to proceed because if falls within the ODG Guidleines for tensynovitis" for the work hardening program from the adjustor, Terry Vangen. The submitted documentation does not contain a preauthorization approval for the work hardening program; therefore, the work hardening program is subject to concurrent review in accordance with 28 Texas Administrative Code §134.600. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. 28 Texas Administrative Code §137.100 Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. Documentation was not submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution. Therefore, the requestor has not met the requirements of the rules.
2. The respondent states in their position summary that the requestor did not seek reconsideration for the disputed services. In accordance with 28 Texas Administrative Code 133.250(d) The request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill; (2) include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to the insurance carrier; (3) include any necessary and related documentation not submitted with the original medical bill to support the health care provider's position; and (4) include a bill-specific, substantive explanation in accordance with §133.3 of this chapter (relating to Communication Between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment. Documentation was not submitted to support the request for reconsideration was made. Therefore, the requestor has not met the requirements of the rule.
3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		June 29, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.